Blank Children's Hospital
UnityPoint Health

Pediatric Therapy Case History

Please answer the following questions **BEFORE** your child's evaluation. This information will be used for all therapies: Speech, Occupational and Physical Therapy. Do not complete if you have already done so for a previous evaluation. **Please notify us if you cannot keep your appointment for the evaluation.** Also, please notify us as soon as possible if your phone number, address, or insurance has changed since the appointment was made.

Child's Name: _____ Nickname: _____ Date of Birth: _____

Name of person completing form: _____ Relationship to child: _____

Describe your concerns about your child. Please include examples: _____

_____

_____

What are your goals/expectations of this evaluation and/or if therapy is recommended? _____

_____

_____

Pregnancy and Birth History

Were there any previous pregnancies? ☐**Yes** ☐**No** ☐**Unknown**

During this pregnancy, did the child's mother experience any unusual illness, condition, or accident (e.g., German measles, Rh/blood incompatibility, toxemia, maternal diabetes)? ☐**Yes** ☐**No** ☐**Unknown**

If **yes**, please describe: _____

Any drug or alcohol use during pregnancy? ☐**Yes** ☐**No** ☐**Unknown** ☐**Suspected**

If **yes/suspected**, please describe: _____

Length of Pregnancy: _____ Type of Delivery: ☐**Cesarean** **or** ☐**Vaginal**

Child's birth weight: _____ Length of hospital stay after birth: _____

Was your infant in the Intensive Care Nursery? ☐**Yes** **or** ☐**No** For how long? _____

Were any of the following present after birth? (Check all that apply.)

	☑
Seizure Activity	
Feeding difficulties / Difficulty sucking or swallowing	
Difficulty regaining birth weight	
Need for oxygen	

Developmental Motor Milestones/History

Did/does your child tolerate tummy time? ☐**Yes** ☐**No** ☐**Unknown**

What age did your child do the following? **OR** Check if no concerns:☐

	Age		**Age**
First hold head alone		Crawl (check one) ☐ **Hands and knees** or ☐**tummy**	
Roll tummy to back		Pull up to standing	
Roll back to tummy		Walk without support	
Sit alone without support		Become completely toilet trained	

Case history reviewed: February 20, 2019

Does your child have any physical limitations at this time? ☐**Yes** ☐**No** **If yes**, list: _____

Medical History

Allergies? ☐**Yes** ☐**No** If **yes**, please list: _____ **LATEX ALLERGY?** ☐**Yes** ☐ **No**

List medical conditions (e.g., Autism, ADHD, Epilepsy, Cerebral Palsy, heart condition, hearing loss, visual impairments) and age at diagnosis:

Condition:_____ **Age:** _____
Condition:_____ **Age:** _____
Condition:_____ **Age:** _____
Condition:_____ **Age:** _____
Condition:_____ **Age:** _____

Others: _____

List childhood illnesses/diseases, age, and treatment received (e.g., ear infections):

Illness: _____ **Age:** _____ **Treatment:** _____
Illness: _____ **Age:** _____ **Treatment:** _____
Illness: _____ **Age:** _____ **Treatment:** _____
Illness: _____ **Age:** _____ **Treatment:** _____
Illness: _____ **Age:** _____ **Treatment:** _____

Others: _____

Has your child been admitted to the hospital since birth? ☐**Yes** ☐**No** If **yes,** provide dates, and reasons:

Date: _____ **Reason:**_____
Date: _____ **Reason:**_____
Date: _____ **Reason:**_____
Date: _____ **Reason:**_____
Date: _____ **Reason:**_____

Others: _____

_____

List current medications: (Include Botox injections.) **OR** Bring list of current medications.

Medication: _____ **Reason:** _____
Medication: _____ **Reason:** _____
Medication: _____ **Reason:** _____
Medication: _____ **Reason:** _____
Medication: _____ **Reason:** _____
Medication: _____ **Reason:** _____

Others: _____

Do you have any concerns with the following? (Check all that apply **AND** explain below.)

	☑		☑
Attention		Eating/Drinking	
Avoids/Seeks Sensations (touch/sound/sight)		Hearing	
Behavior		Movement/Toe Walking	
Breathing/Respiratory		Sleep	
Communication		Vision	
Dressing		Other _____	

Explain: _____

_____

_____

Previous Evaluations and Therapy

Has your child had any of the following evaluations? (Check all that apply and provide details.)

☐Developmental Evaluation Where: _____ When:_____ Outcome: _____
☐Hearing Evaluation Where: _____ When:_____ Outcome: _____
☐Neurological Evaluation Where: _____ When:_____ Outcome: _____
☐Psychological Evaluation Where: _____ When:_____ Outcome: _____
☐Vision Evaluation Where: _____ When:_____ Outcome: _____

Has your child participated in any therapies? (Check all that apply and provide details.)

☐Speech/Language Therapy Where: _____ Start Date:_____ End Date: _____
Goals Targeted: _____

☐Physical Therapy Where: _____ Start Date:_____ End Date: _____
Goals Targeted: _____

☐Occupational Therapy Where: _____ Start Date:_____ End Date: _____
Goals Targeted: _____

☐Feeding Therapy Where: _____ Start Date:_____ End Date: _____
Goals Targeted: _____

☐ABA (Applied Behavioral Analysis) Therapy Where: _____ Start Date:_____ End Date: _____
Goals Targeted: _____

Others: _____

Educational History

Who cares for your child during the day? ☐**Mom** ☐**Dad** ☐**Guardian**
☐**Relative** ☐**Nanny** ☐**In-home** ☐**Daycare Center**

Are they involved with Early ACCESS or your local Area Educational Agency (e.g., Heartland AEA)? ☐**Yes** ☐**No**

If **yes**, how often do they receive services? _____ What specialties? _____

Do they attend an Early Education Program (age 3-5) or Head Start? ☐**Yes** ☐**No**

Do they attend preschool or school? ☐**Yes** ☐**No** If **yes**, where? _____ Grade? _____

Has your child had difficulty with school work? ☐**Yes** ☐**No** **N/A** If **yes**, explain: _____

_____

Does your child have an IEP (Individualized Education Plan) or 504 Plan? ☐**Yes** ☐**No** ☐**N/A**

If **yes**, list areas/subjects: _____

Is your child enrolled in any special education classes? ☐**Yes** ☐**No** ☐**N/A** If **yes**, explain: _____

Does your child receive 1-on-1 assistance during their school day? ☐**Yes** ☐**No** ☐**N/A**

Has your child repeated any grades? ☐**Yes** ☐**No** ☐**N/A**

Social History

Does your child participate in any community resources? ☐**Yes** ☐**No** If **yes**, explain: _____

What are your child's favorite toys and/or entertainment? _____

_____

How does your child play with others? _____

How much screen time (e.g., phone, tablet, TV, video games) does your child engage in each day? _____ (mins / hrs)

Family History

Name of Caregiver: _____ Relationship to child: _____

Occupation: _____ Employer: _____

Name of Caregiver: _____ Relationship to child: _____

Occupation: _____ Employer: _____

List other people living in the home, their age, and their relationship to your child: _____

_____

Who has custody? _____

Is there a **family history** of any of the following? (Check all that apply, describe relationship to child, and explain below.)

☐Autism - Relation to child: _____

☐Chromosome Deficiency – Relation to child: _____

☐Eye Disorder – Relation to child: _____

☐Genetic Disorder – Relation to child: _____

☐Learning Disabilities – Relation to child: _____

☐Mental Health Disorder – Relation to child: _____

☐Speech and/or Language Delays – Relation to child: _____

☐Other: _____

Explain: _____

Additional Information

Please add any additional information that may be helpful for your child's evaluation: _____

_____

_____

How would you rate your level of concern regarding your child's difficulties? (Please check.)

(Least Concerned) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Most Concerned)

For Office Use Only:

Insurance: _____ Secondary Insurance: _____